

		FOR OHF USE					

LL1

2004  
STATE OF ILLINOIS  
DEPARTMENT OF PUBLIC AID  
FINANCIAL AND STATISTICAL REPORT FOR  
LONG-TERM CARE FACILITIES  
(FISCAL YEAR 2004)

IMPORTANT NOTICE  
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0029199

Facility Name: BURGESS SQUARE HEALTHCARE CTR

Address: 5801 S. CASS AVENUE WESTMONT 60559  
Number City Zip Code

County: DUPAGE

Telephone Number: ( 603 ) 971-2645 Fax # ( 630 ) 971-1961

IDPA ID Number: 36-3328030001

Date of Initial License for Current Owners: 04/04/85

Type of Ownership:

<input type="checkbox"/>	VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/>	PROPRIETARY	<input type="checkbox"/>	GOVERNMENTAL
<input type="checkbox"/>	Charitable Corp.	<input type="checkbox"/>	Individual	<input type="checkbox"/>	State
<input type="checkbox"/>	Trust	<input type="checkbox"/>	Partnership	<input type="checkbox"/>	County
IRS Exemption Code		<input checked="" type="checkbox"/>	Corporation	<input type="checkbox"/>	Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:  
Name: BOB KAGDA Telephone Number: ( 847 ) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2004 to 12/31/2004 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider	(Signed)		(Date)
	(Type or Print Name)	JACQUELINE L. MASON	
	(Title)	PRESIDENT	
Paid Preparer	(Signed)	(SEE ATTACHED ACCOUNTANTS' REPORT)	
			(Date)
	(Print Name and Title)	BOB KAGDA PARTNER	
	(Firm Name & Address)	KRUPNICK BOKOR KAGDA & BROOKS, LTD 3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1124	
	(Telephone)	( 847 ) 675-3585 Fax # ( 847 ) 675-5777	
MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630			

Facility Name & ID Number

BURGESS SQUARE HEALTHCARE CTR

#

0029199

Report Period Beginning:

01/01/2004

Ending:

12/31/2004

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	102	Skilled (SNF)	102	37,332	1
2		Skilled Pediatric (SNF/PED)			2
3	105	Intermediate (ICF)	105	38,430	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	207	TOTALS	207	75,762	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF			6,463	6,463	8
9	SNF/PED					9
10	ICF	32,111	24,501	1,038	57,650	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	32,111	24,501	7,501	64,113	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.)

84.62%

D. How many bed-hold days during this year were paid by Public Aid?

0

(Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

NONE

F. Does the facility maintain a daily midnight census?

YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES

NO

X

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES

NO

X

I. On what date did you start providing long term care at this location?

Date started

12/01/84

J. Was the facility purchased or leased after January 1, 1978?

YES

X

Date

12/01/84

NO

K. Was the facility certified for Medicare during the reporting year?

YES

X

NO

If YES, enter number of beds certified

74

and days of care provided

6,463

Medicare Intermediary

MUTUAL OF OMAHA

IV. ACCOUNTING BASIS

ACCRUAL

X

MODIFIED CASH\*

CASH\*

Is your fiscal year identical to your tax year?

YES

X

NO

Tax Year:

12/31/2004

Fiscal Year:

12/31/2004

\* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number **BURGESS SQUARE HEALTHCARE CTR** # **0029199** Report Period Beginning: **01/01/2004** Ending: **12/31/2004**

**V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)**

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>A. General Services</b>											
1	Dietary	386,258	28,507	32,373	447,138		447,138		447,138			1
2	Food Purchase		324,725		324,725		324,725	(5,727)	318,998			2
3	Housekeeping	327,218	44,669		371,887		371,887		371,887			3
4	Laundry	101,347	27,957	4,077	133,381		133,381		133,381			4
5	Heat and Other Utilities			204,810	204,810		204,810		204,810			5
6	Maintenance	112,363	50,629	35,357	198,349		198,349		198,349			6
7	Other (specify):*			15,134	15,134		15,134		15,134			7
8	<b>TOTAL General Services</b>	927,186	476,487	291,751	1,695,424		1,695,424	(5,727)	1,689,697			8
	<b>B. Health Care and Programs</b>											
9	Medical Director			21,500	21,500		21,500		21,500			9
10	Nursing and Medical Records	3,043,565	149,079	107,620	3,300,264		3,300,264	5,521	3,305,785			10
10a	Therapy	498,976	6,969		505,945		505,945		505,945			10a
11	Activities	209,662	13,638	5,256	228,556		228,556		228,556			11
12	Social Services	88,149		3,574	91,723		91,723		91,723			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*							1,158	1,158			15
16	<b>TOTAL Health Care and Programs</b>	3,840,352	169,686	137,950	4,147,988		4,147,988	6,679	4,154,667			16
	<b>C. General Administration</b>											
17	Administrative	189,452		302,196	491,648		491,648	(39,196)	452,452			17
18	Directors Fees											18
19	Professional Services			86,727	86,727		86,727	3,539	90,266			19
20	Dues, Fees, Subscriptions & Promotions			62,387	62,387		62,387	(16,155)	46,232			20
21	Clerical & General Office Expenses	125,970	47,810	89,694	263,474		263,474	(30,004)	233,470			21
22	Employee Benefits & Payroll Taxes			962,549	962,549		962,549		962,549			22
23	Inservice Training & Education			7,643	7,643		7,643		7,643			23
24	Travel and Seminar							376	376			24
25	Other Admin. Staff Transportation			1,874	1,874		1,874		1,874			25
26	Insurance-Prop.Liab.Malpractice			157,249	157,249		157,249	784	158,033			26
27	Other (specify):*							33,952	33,952			27
28	<b>TOTAL General Administration</b>	315,422	47,810	1,670,319	2,033,551		2,033,551	(46,704)	1,986,847			28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	5,082,960	693,983	2,100,020	7,876,963		7,876,963	(45,752)	7,831,211			29

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

## V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE		SCHED REF	TOTAL
1	<b>DIETARY</b>		
	DIETITIAN CONSULTANT	XVIII B 35-2	16,548
	REPAIRS & MAINTENANCE		15,825
			0
			32,373
3	<b>HOUSEKEEPING</b>		
			0
			0
			0
4	<b>LAUNDRY</b>		
	EQUIPMENT REPAIRS & MAINTENANCE		4,077
			0
			4,077
5	<b>HEAT &amp; OTHER UTILITIES</b>		
	GAS HEAT		59,509
	ELECTRICITY		83,707
	WATER		61,594
	CABLE TV - LOBBY		0
			0
			204,810
6	<b>MAINTENANCE</b>		
	GROUNDS MAINTENANCE		5,950
	PAINTING & DECORATING		669
	BUILDING REPAIRS		1,872
	MAINTENANCE TRAVEL		0
	EQUIPMENT MAINTENANCE & REPAIR		17,950
	ELEVATOR MAINTENANCE & REPAIR		6,533
	OUTSIDE LABOR		0
	EXTERMINATING SERVICE		2,383
	FIRE SERVICE		0
			0
			0
			0
			35,357
7	<b>OTHER</b>		
	SCAVENGER		14,884
	SECURITY SERVICE		250
			15,134
9	<b>MEDICAL DIRECTOR</b>		
	MEDICAL DIRECTOR FEES	XVIII B 36-2	21,500
			21,500

LINE		SCHED REF	TOTAL
10	<b>NURSING</b>		
	CONTRACT NURSING	XVIII C 53-2	75,038
	LABORATORY & XRAY EXPENSE		0
	PURCHASED SERVICES		0
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	4,536
	PHARMACY CONSULTANT	XVIII B 39-2	2,101
	UTILIZATION REVIEW FEES	XVIII B __-2	0
	PHYSICIANS	XVIII B __-2	0
	PSYCHIATRIC	XVIII B __-2	0
	RN CONSULTANT	XVIII B 38-2	27,805
			0
	SALARIES REBILLED		(1,860)
			107,620
10a	<b>THERAPY</b>		
	PHYSICAL THERAPY SERVICES		0
	SPEECH THERAPY SERVICES		0
	OCCUPATIONAL THERAPY SERVICES		0
	REHABILITATION CONSULTANT	XVIII B __-2	0
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	0
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	0
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0
			0
11	<b>ACTIVITIES</b>		
	CABLE TV - PATIENT ROOMS		2,625
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	2,631
			0
			5,256
12	<b>SOCIAL SERVICES</b>		
	SOCIAL REHABILITATION SERVICES		0
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	0
	SOCIAL WORKER	XVIII B 45-2	3,574
			0
			3,574
13	<b>NURSE AIDE TRAINING</b>		
	NURSE AIDE TRAINING COSTS	XIII	0
			0

V.COST CENTER EXPENSES

PAGE 3 COLUMN 3 OTHER

LINE		SCHED REF	TOTAL
14	PROGRAM TRANSPORTATION		
	PATIENT TRANSPORTATION	0	0
17	ADMINISTRATIVE		
	MANAGEMENT FEES	XIX B 302,196	302,196
18	DIRECTORS FEES	0	0
19	PROFESSIONAL SERVICES		
	DATA PROCESSING	XIX C 6,461	
	ADMINISTRATIVE CONSULTANTS	XIX C 0	
	PROFESSIONAL FEES	XIX C 80,266	
		0	86,727
20	FEES,SUBSCRIPTIONS,PROMOTIONS		
	ENTERTAINMENT & MARKETING	VI 19 XIX F 0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F 14,120	
	EMPLOYEE WANT ADS	XIX F 33,405	
	CONTRIBUTIONS	VI 20 XIX F 500	
	DUES & SUBSCRIPTIONS	XIX F 8,716	
	LICENSES & PERMITS	XIX F 455	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F 0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F 819	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F 200	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F 662	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F 3,510	62,387
21	CLERICAL & GENERAL OFFICE EXPENSES		
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	4,170	
	EQUIPMENT REPAIR & MAINTENANCE	918	
	OUTSIDE CLERICAL SERVICES	38,000	
	PENALTIES / OVERDRAFT CHARGES	VI 18 0	
	HOME OFFICE EXPENSE	0	
	THEFT & DAMAGE LOSS	3,306	
	TELEPHONE	43,198	
	MESSENGER SERVICE	102	
		0	89,694

LINE		SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES		
	FICA TAXES	XIX D 388,738	
	UNEMPLOYMENT COMPENSATION	XIX D 39,107	
	WORKERS COMPENSATION INSURANCE	XIX D 132,819	
	HOSPITALIZATION INSURANCE	XIX D 347,639	
	EMPLOYEE BENEFITS - OTHER	XIX D 54,246	
	EMPLOYEE PHYSICAL EXAMS	XIX D 0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D 0	
	PENSION/PROFIT SHARING PLANS	XIX D 0	
	CHICAGO HEAD TAX	XIX D 0	962,549
23	INSERVICE TRAINING & EDUCATION		
	EDUCATION & SEMINARS	7,643	7,643
24	TRAVEL & SEMINARS		
	EDUCATION & SEMINARS	XIX G 0	
	TRAVEL	XIX G 0	
		0	
		0	0
25	ADMIN. STAFF TRANSPORTATION		
	TRANSPORTATION - STAFF	1,874	1,874
26	INSURANCE - PROP. LIAB & MALPRACTICE		
	GENERAL INSURANCE	157,249	157,249
27	OTHER		
	BAD DEBTS	VI 24 0	
			0

GRAND TOTAL COLUMN 3 OTHER

2,100,020

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			46,796	46,796		46,796	45,207	92,003			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			9,284	9,284		9,284	(1,110)	8,174			32
33	Real Estate Taxes			96,078	96,078		96,078		96,078			33
34	Rent-Facility & Grounds			823,987	823,987		823,987		823,987			34
35	Rent-Equipment & Vehicles			42,407	42,407		42,407		42,407			35
36	Other (specify):*											36
37	TOTAL Ownership			1,018,552	1,018,552		1,018,552	44,097	1,062,649			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		178,533	104,483	283,016		283,016		283,016			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			113,644	113,644		113,644		113,644			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		178,533	218,127	396,660		396,660		396,660			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	5,082,960	872,516	3,336,699	9,292,175		9,292,175	(1,655)	9,290,520			45

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.  
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	45,014	30		9
10	Interest and Other Investment Income	(1,110)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,659)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(200)	20		17
18	Fines and Penalties		21		18
19	Entertainment		20		19
20	Contributions	(1,162)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt		27		24
25	Fund Raising, Advertising and Promotional	(14,120)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(819)	20		28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ 25,944		\$	30

OHF USE ONLY							
48		49		50		51	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(27,599)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (27,599)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B) )	\$ (1,655)		37

\*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification.  
(See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

ID#0029199

Report Period Beginning:01/01/2004

Ending:12/31/2004

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	\$ 0	6	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

## Summary A

**12/31/2004**

[illegible]

## Summary B

**12/31/2004**

**SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I**

[illegible]

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
JACQUELINE MASON	70%	N/A		UNITED CARE	OVANDO, MONTANA	MGMT CO
MONTY MILLER	30%			MGMT PROF FOR HC	CLARENDON HILLS, IL	BKKP CONSLT

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	MANAGEMENT FEES	\$ 302,196	UNITED CARE	100.00%	\$	\$ (302,196)	1
2	V								2
3	V								3
4	V	17	ADMINISTRATIVE				263,000	263,000	4
5	V	27	EMPLOYEE BENEFITS				32,281	32,281	5
6	V	19	PROFESSIONAL FEES				1,500	1,500	6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 302,196			\$ 296,781	\$ * (5,415)	14

\* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	2	DIETARY CONSULTANT	\$ 4,068	MANAGEMENT PROFESSIONALS FOR HEALTHCARE	60.00%	\$	\$ (4,068)	15
16	V	10	NURSING CONSULTANT	7,349				(7,349)	16
17	V	21	ADMISSIONS CONSULTANT	15,288				(15,288)	17
18	V	21	OTHER PROF.-BOOKKEEPING	38,000				(38,000)	18
19	V								19
20	V								20
21	V								21
22	V	19	PROFESSIONAL FEES				2,039	2,039	22
23	V	20	DUES, SUBSCRIPTIONS				146	146	23
24	V	21	CLERICAL & GENERAL				4,714	4,714	24
25	V	24	SEMINARS				376	376	25
26	V	26	INSURANCE				784	784	26
27	V	30	DEPRECIATION				193	193	27
28	V								28
29	V								29
30	V								30
31	V								31
32	V	10	NURSING SALARIES				12,870	12,870	32
33	V	15	EMPLOYEE BENEFITS				1,158	1,158	33
34	V	21	CLERICAL SALARIES				18,570	18,570	34
35	V	27	EMPLOYEE BENEFITS				1,671	1,671	35
36	V								36
37	V								37
38	V								38
39	Total			\$ 64,705			\$ 42,521	\$ * (22,184)	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number **BURGESS SQUARE HEALTHCARE CTR** # **0029199** Report Period Beginning: **01/01/2004** Ending: **12/31/2004**

**VII. RELATED PARTIES (continued)**

**C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.**

**NOTE: ALL owners ( even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.**

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	JACQUELINE MASON	PRESIDENT	ADMIN	70.00	N/A	40	80.00	SALARY	\$ 150,000	17-7	1
2	MONTY MILLER	VICE PRESIDENT	ADMIN	30.00	N/A	35	87.50	SALARY	113,000	17-7	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 263,000		13

\* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

\*\* This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number BURGESS SQUARE HEALTHCARE CTR # 0029199 Report Period Beginning: 01/01/2004 Ending: 2/31/2004

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization \_\_\_\_\_  
Street Address \_\_\_\_\_  
City / State / Zip Code \_\_\_\_\_  
Phone Number (\_\_\_\_) \_\_\_\_\_  
Fax Number (\_\_\_\_) \_\_\_\_\_

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

Facility Name & ID Number     BURGESS SQUARE HEALTHCARE CTR     #   0029199   Report Period Beginning:     01/01/2004     Ending:   2/31/2004

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.)     YES ☒     NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization     UNITED CARE INC  
Street Address     PO BOX 103  
City / State / Zip Code     OVANDO, MONTANA 59854  
Phone Number     ( 406-793-5002 from Internet  
Fax Number     ( )

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	19	PROFESSIONALS FEES	MGMT FEE INCOME			\$	\$			1
2	20	DUES, SUBSCRIPTIONS	MGMT FEE INCOME							2
3	21	CLERICAL & GENERAL	MGMT FEE INCOME							3
4	30	DEPRECIATION	MGMT FEE INCOME							4
5	32	INTEREST	MGMT FEE INCOME							5
6										6
7										7
8										8
9	17	ADMINISTRATIVE	AVG HOURS-MASON							9
10	27	EMPLOYEE BENEFITS	AVG HOURS-MASON							10
11										11
12										12
13										13
14	17	ADMINISTRATIVE	AVG HOURS-MILLER							14
15	21	CLERICAL & GENERAL	AVG HOURS-MILLER							15
16	27	EMPLOYEE BENEFITS	AVG HOURS-MILLER							16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10			
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense				
		YES	NO				Original	Balance							
	A. Directly Facility Related Long-Term														
1							\$		\$			\$	1		
2													2		
3													3		
4													4		
5													5		
	Working Capital														
6	LASALLE BANK		X	WORKING CAPITAL					397,000			9,284	6		
7													7		
8													8		
9	TOTAL Facility Related						\$		\$	397,000			\$	9,284	9
	B. Non-Facility Related*														
10													10		
11													11		
12													12		
13													13		
14	TOTAL Non-Facility Related						\$		\$				\$		14
15	TOTALS (line 9+line14)						\$		\$	397,000			\$	9,284	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V.      \$ N/A      Line #

\* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.  
(See instructions.)

\*\* If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.  
(See instructions.)

## B. Real Estate Taxes

**THE PAYMENT ON LINE 2 APPLIES TO THE 2003 TAX BILL.**

1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.  
**This denial must be no more than four years old at the time the cost report is filed.**

IMPORTANT NOTICE

TO:

Long Term Care Facilities with Real Estate Tax Rates

RE:

2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME

BURGESS SQUARE HEALTHCARE CTR

COUNTY

DUPAGE

FACILITY IDPH LICENSE NUMBER

0029199

CONTACT PERSON REGARDING THIS REPORT

BOB KAGDA

TELEPHONE ( 847 ) 675-3585

FAX #: ( 847 ) 675-5777

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

	(A)	(B)	(C)	(D)
				<u>Tax</u>
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Applicable to</u>
				<u>Nursing Home</u>
1.	09-15-107-044	LONG TERM CARE PROPERTY	\$ 96,084.88	\$ 96,084.88
2.			\$	\$
3.			\$	\$
4.			\$	\$
5.			\$	\$
6.			\$	\$
7.			\$	\$
8.			\$	\$
9.			\$	\$
10.			\$	\$
		TOTALS	\$ 96,084.88	\$ 96,084.88

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 57,000

B. General Construction Type: Exterior BRICK Frame STEEL STRUCTURE Number of Stories 2

C. Does the Operating Entity? ☐ (a) Own the Facility ☐ (b) Rent from a Related Organization. ☒ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? ☒ (a) Own the Equipment ☐ (b) Rent equipment from a Related Organization. ☒ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? ☐ YES ☒ NO

If so, please complete the following:

1. Total Amount Incurred: \_\_\_\_\_

2. Number of Years Over Which it is Being Amortized: \_\_\_\_\_

3. Current Period Amortization: \_\_\_\_\_

4. Dates Incurred: \_\_\_\_\_

Nature of Costs: \_\_\_\_\_  
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1				\$	1
2					2
3	TOTALS			\$	3

XI. OWNERSHIP COSTS (continued)
 B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	2	3	4	5	6	7	8	9	
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4					\$	\$		\$	\$	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9	VARIOUS		1985		86,486	3,775	20	3,845	70	82,685
10	VARIOUS		1986		87,317	4,540	20	106	(4,434)	86,613
11	VARIOUS		1987		10,202	324	20		(324)	10,196
12	VARIOUS		1988		11,485	382	20	574	192	9,458
13	VARIOUS		1989		25,270	600	20	1,264	664	19,753
14	VARIOUS		1990		52,220	750	20	2,612	1,862	38,966
15	VARIOUS		1991		27,798	1,303	20	413	(890)	27,213
16	VARIOUS		1992		12,659	370	20	633	263	7,772
17	VARIOUS		1993		342,712	10,052	20	17,135	7,083	192,205
18	VARIOUS		1994		16,249	417	20	813	396	8,785
19	VARIOUS		1995		20,503	526	20	1,025	499	9,753
20	VARIOUS		1996		23,823	611	20	1,191	580	9,986
21	VARIOUS		1997		29,589	759	20	1,479	720	11,303
22	VARIOUS		1998		36,702	967	20	1,837	870	12,233
23	VARIOUS		1999		88,002	2,228	20	4,399	2,171	23,893
24	VARIOUS		2000		195,196	5,005	20	9,761	4,756	46,619
25										25
26										26
27										27
28										28
29										29
30										30
31										31
32										32
33										33
34										34
35										35
36										36

\*Total beds on this schedule must agree with page 2.
 \*\*Improvement type must be detailed in order for the cost report to be considered complete.
 See Page 12A, Line 70 for total

**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	ELEVATOR IMPROVEMENT	2001	\$ 2,150	\$ 55	20	\$ 108	\$ 53	\$ 431	37
38	HOT WATER TANK	2001	5,646	145	20	282	137	1,106	38
39	ROOF IMPROVEMENT	2001	11,275	289	20	564	275	2,162	39
40	DOORS	2001	1,595	41	20	80	39	300	40
41	ELECTRICAL WALL PAKS	2001	1,258	32	20	63	31	231	41
42	ELECTRICAL WORK	2001	1,795	46	20	90	44	300	42
43	CARPETS	2001	5,009		20	501	501	1,670	43
44	SIGNS	2001	3,000		20	300	300	1,000	44
45	HVAC UNIT	2001	11,500	295	20	575	280	1,869	45
46	HVAC UNIT	2001	11,500	295	20	575	280	1,821	46
47	SIGNS	2001	930		20	93	93	295	47
48	SIGNS	2001	2,526		20	253	253	800	48
49	PLUMBING	2001	11,314	290	20	566	276	1,744	49
50	CARPENTRY	2001	1,607	41	20	80	39	248	50
51	CALL STATION	2001	1,536		20	77	77	250	51
52	NETWORK CABLES	2001	987		20	49	49	168	52
53	TELEPHONE	2001	770		20	39	39	126	53
54	ELECTRIC RANGE	2001	1,036		20	52	52	160	54
55	CALL STATION	2001	568		20	28	28	113	55
56	TILE	2001	582		20	29	29	109	56
57	TILE	2001	1,187		20	59	59	222	57
58	TELEPHONE	2001	599		20	30	30	103	58
59	PLUMBING	2001	809		20	40	40	131	59
60	HEAT EXCHANGER	2001	1,400		20	70	70	228	60
61	TILE	2001	539		20	27	27	90	61
62	SECURITY SYSTEM	2001	1,072		20	54	54	175	62
63	HEAT EXCHANGER	2001	710		20	36	36	116	63
64	TIME CLOCK/LIGHTS AN	2001	1,395		20	70	70	222	64
65	BLOWER/IGNITOR	2001	652		20	33	33	101	65
66	COOLER	2001	1,226		20	61	61	189	66
67	EXHAUST	2002	925		20	93	93	247	67
68	GENERATOR	2002	2,018		20	202	202	538	68
69	PAINTING	2002	1,980		20	198	198	578	69
70	TOTAL (lines 4 thru 69)		\$ 1,157,309	\$ 34,138		\$ 52,464	\$ 18,326	\$ 615,276	70

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)
 B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 1,157,309	\$ 34,138		\$ 52,464	\$ 18,326	\$ 615,276	1
2	PAINTING	2002	700		20	70	70	198	2
3	SHELVING	2002	830		20	83	83	235	3
4	EXHAUST FAN	2002	1,525		20	153	153	445	4
5	HEAT EXCHANGER	2002	2,200		20	220	220	495	5
6	FREEZER	2002	608		20	61	61	167	6
7	COMPRESSOR	2002	618		20	62	62	186	7
8	VACUUM PUMP	2002	645		20	65	65	162	8
9	PLUMBING	2002	781		20	78	78	182	9
10	BATTERY	2002	567		20	57	57	142	10
11	CEILING TILES	2002	1,826		20	183	183	503	11
12	FIRE DOORS	2002	3,921		20	392	392	1,013	12
13	TILES	2002	1,132		20	113	113	321	13
14	PIPE	2002	550		20	55	55	142	14
15	COMPRESSOR	2002	1,483		20	148	148	383	15
16	PLUMBING	2002	629		20	63	63	178	16
17	TILE STRIP/WAX	2002	7,000		20	700	700	2,100	17
18	HVAC UNIT	2003	12,150		20	405	405	810	18
19	PIPING/PLUMBING	2003	5,250		20	241	241	482	19
20	SIDEWALK REMOVAL/REPAIR	2003	3,300		20	41	41	82	20
21	ELEVATOR REPAIR	2003	1,158		20	29	29	58	21
22	DOOR FRAME REPAIR	2003	679		20	28	28	56	22
23	FAN REPAIRS	2003	500		20	15	15	30	23
24	COMPRESSOR REPAIR	2003	1,065		20	40	40	80	24
25	COMPRESSOR REPAIR	2003	825		20	31	31	62	25
26	COMPRESSOR REPAIR	2003	591		20	15	15	30	26
27	CONDENSOR FAN MOTOR	2003	537		20	11	11	22	27
28	WATER HEATER	2004	5,400	63	39	63		63	28
29	NEW HEATING UNIT	2004	12,250	144	39	144		144	29
30	20 FT STORM PIPE	2004	4,500	53	39	53		53	30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,230,529	\$ 34,398		\$ 56,083	\$ 21,685	\$ 624,100	34

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)								
	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 353,323	\$ 11,078	\$ 35,333	\$ 24,255	10	\$ 225,964	71
72	Current Year Purchases	7,879	1,320	394	(926)	10	394	72
73	Fully Depreciated Assets	223,394				10	223,394	73
74	RELATED PARTY		193	193				74
75	TOTALS	\$ 584,596	\$ 12,591	\$ 35,920	\$ 23,329		\$ 449,752	75

D. Vehicle Depreciation (See instructions.)*									
	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9
76		VAN	1998	\$ 22,421	\$	\$	\$	5	\$ 22,421
77									
78									
79									
80	TOTALS			\$ 22,421	\$	\$	\$		\$ 22,421

E. Summary of Care-Related Assets					1	2
		Reference			Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)			\$ 1,837,546	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$ 46,989	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$ 92,003	
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$ 45,014	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$ 1,096,273	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)				
	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4
86		\$	\$	\$
87				
88				
89				
90				
91	TOTALS	\$	\$	\$

G. Construction-in-Progress		
	Description	Cost
92		\$
93		
94		
95		\$

\* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

\*\* This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: CAMELOT HEALTHCARE CENTER
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

☒ YES

☐ NO
- If NO, see instructions.

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		211		\$ 823,987			3
4	Additions							4
5								5
6								6
7	TOTAL		211		\$ 823,987			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease

9. Option to Buy: ☐ YES ☐ NO Terms: \*

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

☐ YES

☐ NO
16. Rental Amount for movable equipment: \$ 42,407 Description: SEE SCHEDULE ATTACHED
- (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$ 0	21

10. Effective dates of current rental agreement:

Beginning

Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2005	\$
13.	/2006	\$
14.	/2007	\$

\* If there is an option to buy the building, please provide complete details on attached schedule.

\*\* This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?

☐ YES

☒ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER AIDE

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER AIDE

THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

B. EXPENSES

		ALLOCATION OF COSTS		(d)	
		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$ 47,969	\$		\$ 47,969	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			6,579			6,579	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			615			615	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				178,423		178,423	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	SUPPLIES. LAB,RENTALS,RADIOLOGY Other (specify): OTHER SVC	39-3					49,430		49,430	13
14	TOTAL			\$		\$ 55,163	\$ 227,853		\$ 283,016	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 330,183	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	1,374,204		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	253,042		6
7	Other Prepaid Expenses	32,049		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$ 1,989,478	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	1,104,008		15
16	Equipment, at Historical Cost	607,019		16
17	Accumulated Depreciation (book methods)	(976,528)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets</b> (sum of lines 11 thru 23)	\$ 734,499	\$	24
25	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$ 2,723,977	\$	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 338,285	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	397,000		29
30	Accrued Salaries Payable	244,353		30
31	Accrued Taxes Payable (excluding real estate taxes)	30,447		31
32	Accrued Real Estate Taxes(Sch.IX-B)	96,240		32
33	Accrued Interest Payable	415		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36				36
37				37
38	<b>TOTAL Current Liabilities</b> (sum of lines 26 thru 37)	\$ 1,106,740	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities</b> (sum of lines 39 thru 44)	\$	\$	45
46	<b>TOTAL LIABILITIES</b> (sum of lines 38 and 45)	\$ 1,106,740	\$	46
47	<b>TOTAL EQUITY</b> (page 18, line 24)	\$ 1,617,237	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 46 and 47)	\$ 2,723,977	\$	48

\*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,762,113	1
2	Restatements (describe):		2
3	IL REPLACEMENT TAX	9,262	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,771,375	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	200,157	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(354,295)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (154,138)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,617,237	24 *

\* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.  
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

1			
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 9,291,993	1
2	Discounts and Allowances for all Levels	( )	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 9,291,993	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	205,906	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 205,906	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,110	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,110	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	VENDING COMMISSIONS - NET	2,604	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 2,604	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 9,501,613	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,695,424	31
32	Health Care	4,147,988	32
33	General Administration	2,033,551	33
	B. Capital Expense		
34	Ownership	1,018,552	34
	C. Ancillary Expense		
35	Special Cost Centers	283,016	35
36	Provider Participation Fee	113,644	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 9,292,175	40
41	Income before Income Taxes (line 30 minus line 40)**	209,438	41
42	Income Taxes	(9,281)	42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 200,157	43

\* This must agree with page 4, line 45, column 4.

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.  
TAX RETURN PREPARED ON CASH BASIS

\*\*\* See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

\*\*\*\*Provide a detailed breakdown of "Other Revenue" on an attached sheet.

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)  
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,888	2,032	\$ 60,462	\$ 29.75	1
2	Assistant Director of Nursing	3,840	4,072	84,477	20.75	2
3	Registered Nurses	18,968	20,643	620,516	30.06	3
4	Licensed Practical Nurses	27,015	29,107	702,739	24.14	4
5	Nurse Aides & Orderlies	120,153	126,684	1,315,820	10.39	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	7,907	8,713	203,195	23.32	7
8	Rehab/Therapy Aides	23,062	25,117	295,781	11.78	8
9	Activity Director	1,800	2,104	37,438	17.79	9
10	Activity Assistants	15,495	16,932	172,224	10.17	10
11	Social Service Workers	3,864	4,240	88,149	20.79	11
12	Dietician					12
13	Food Service Supervisor	4,024	4,938	99,214	20.09	13
14	Head Cook	658	708	7,029	9.93	14
15	Cook Helpers/Assistants	28,749	30,617	280,015	9.15	15
16	Dishwashers					16
17	Maintenance Workers	7,964	8,714	112,363	12.89	17
18	Housekeepers	33,652	36,118	327,218	9.06	18
19	Laundry	7,364	8,241	101,347	12.30	19
20	Administrator	2,024	2,080	97,261	46.76	20
21	Assistant Administrator	4,057	4,353	92,191	21.18	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,246	5,787	125,970	21.77	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	3,839	4,079	46,048	11.29	31
32	Other Health Care(specify)	7,717	8,270	213,503	25.82	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	329,286	353,549	\$ 5,082,960 *	\$ 14.38	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	MONTHLY	\$ 16,548	1-3	35
36	Medical Director	MONTHLY	21,500	9-3	36
37	Medical Records Consultant	MONTHLY	4,536	10-3	37
38	Nurse Consultant		27,805	10-3	38
39	Pharmacist Consultant	MONTHLY	2,101	10-3	39
40	Physical Therapy Consultant		0	10a-3	40
41	Occupational Therapy Consultant		0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant		0	10a-3	43
44	Activity Consultant		2,631	11-3	44
45	Social Service Consultant		3,574	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 78,695		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	2,144	\$ 75,038	10-3	50
51	Licensed Practical Nurses		0	10-3	51
52	Nurse Aides		0	10-3	52
53	TOTAL (lines 50 - 52)	2,144	\$ 75,038		53

\* This total must agree with page 4, column 1, line 45.

\*\* See instructions.

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount		Description	Amount
JO ANNE FISHER	ADMIN		\$ 97,261	Workers' Compensation Insurance	\$	132,819	IDPH License Fee	\$
TRINIDAD SANDOVAL	ASST ADMIN		37,798	Unemployment Compensation Insurance		39,107	Advertising: Employee Recruitment	33,405
KATHLEEN SEFCIK	ASST ADMIN		54,393	FICA Taxes		388,738	Health Care Worker Background Check	3,510
				Employee Health Insurance		347,639	(Indicate # of checks performed )	
				Employee Meals			MARKETING/ADV/PROMO	14,939
				Illinois Municipal Retirement Fund (IMRF)*			TRUST/FRANCHISE/CONTRIB/ETC	1,362
				EMPLOYEE BENEFITS - OTHER		54,246	LICENSES & PERMITS	455
				EMPLOYEE PHYSICAL EXAMS		0	DUES & SUBSCRIPTIONS	8,716
				PENSION/PROFIT SHARING PLANS		0	MGMT CO ALLOCATION	146
TOTAL (agree to Schedule V, line 17, col. 1)				CHICAGO HEAD TAX		0	TRUST/FRANCHISE/CONTRIB/ETC	(1,362)
(List each licensed administrator separately.)			\$ 189,452	INSURANCE - EXECUTIVE LIFE		0	Less: Public Relations Expense	( 0 )
B. Administrative - Other				INSURANCE - EXECUTIVE LIFE VI 21		0	Non-allowable advertising	(14,120)
Description			Amount				Yellow page advertising	(819)
MANAGEMENT FEES			\$ 302,196					
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 302,196	TOTAL (agree to Schedule V,	\$	962,549	TOTAL (agree to Sch. V,	\$ 46,232
(Attach a copy of any management service agreement)				line 22, col.8)			line 20, col. 8)	
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
KRUPNICK BOKOR KAGDA	ACCOUNTING		\$ 17,400				Out-of-State Travel	\$
FROST RUTTENBERG	ACCOUNTING		39,625					
WILDMAN HARROLD ALLEN	LEGAL		479					
DUANE MORRIS	LEGAL		1,474				In-State Travel	
RICHARD PEELO	MEDICARE CONSLT		6,000					0
ACCU MED	DATA PROCESSING		5,940					
MUTUAL OF OMAHA	DATA PROCESSING		521					
MGMT PROFESSIONALS	ADMISSIONS CONSLT		15,288				Seminar Expense	
								0
							MGMT CO ALLOCATION	376
							Entertainment Expense	( )
							(agree to Sch. V,	
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		\$	line 24, col. 8)	\$ 376
(If total legal fees exceed \$2500 attach copy of invoices.)			\$ 86,727					

\* Attach copy of IMRF notifications

\*\*See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).  
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$ 0	\$	\$	\$	\$	\$

## XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? YES
- (2) Are there any dues to nursing home associations included on the cost report? YES  
If YES, give association name and amount. IHCA \$7,452
- (3) Did the nursing home make political contributions or payments to a political action organization? YES If YES, have these costs been properly adjusted out of the cost report? YES
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases? YES  
What was the average life used for new equipment added during this period? 10 YR
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 32,497 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO  
If YES, give effective date of lease. \_\_\_\_\_
- (9) Are you presently operating under a sublease agreement? \_\_\_\_\_ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES \_\_\_\_\_ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.  
\_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 113,644  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? N/A Indicate the amount. \$ \_\_\_\_\_
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? NO  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ \_\_\_\_\_  
c. What percent of all travel expense relates to transportation of nurses and patients? 5%  
d. Have vehicle usage logs been maintained? NO  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES  
g. Does the facility transport residents to and from day training? NO  
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? NO  
Firm Name: \_\_\_\_\_ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? \_\_\_\_\_ If no, please explain. \_\_\_\_\_
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? YES  
Attach invoices and a summary of services for all architect and appraisal fees